



**Island Coast Pediatrics**

**Phone: (239) 768-2111 FAX: (239) 482-4404**

**Request for Parent or Guardian to receive Copies and/or Inspect Records**

**PEDIATRICS**

The first request are given at no charge. I understand and agree that I am financially responsible for copies that I receive. The cost is \$1.00 per page for the first 25 pages and 25 cents per page thereafter. The records release process takes 7 to 10 business days from the day we receive the release form. I understand that if I wish to inspect the records, that I must do so at Island Coast's Pediatrics' Central Business Office at 12550 Professional Park Dr., Suite 11, Fort Myers, FL 33913. I understand and agree that a representative of Island Coast Pediatrics will be present during such an inspection. If requesting inspection of records, I have been informed that I will be contacted by Island Coast Pediatrics for an appointment at the Central Business Office.

**Name of Patient:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Reason for request:**

**Personal Use** \_\_\_\_\_ **Specialist** \_\_\_\_\_ **Transferring to new physician** \_\_\_\_\_ (Give Reason)

**Reason for Transfer:** \_\_\_\_\_

- Blue & Yellow Forms for School or Daycare-Form required only if being *mailed*)
- Full Medical Summaries – **Full Medical Summaries cannot be faxed.**
- Medical Portion Only/**Date of Service:** \_\_\_\_\_
- Financial Portion Only/**Date of Service:** \_\_\_\_\_
- Other/Specific Information/**Date of Service:** \_\_\_\_\_

**How I will receive:**

- I will pick up the records at \_\_\_\_\_ office.
- I would like them mailed to the address below.

**I am requesting a date/time to inspect the records.-You will be notified of date/time.**

**Printed Name of Requesting Party** \_\_\_\_\_

\_\_\_\_\_  
**Signature of Patient or Legal Guardian**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
Name

Home Tel: \_\_\_\_\_

\_\_\_\_\_  
Street & #

Work Tel: \_\_\_\_\_

\_\_\_\_\_  
City, State & Zip

**Office Use Only:**

- Initial **Contact** for questions/Name Req. (Not initials) \_\_\_\_\_ on \_\_\_\_\_
- Actual **Copies sent** by: \_\_\_\_\_ on \_\_\_\_\_
- Request **added to patient record** by: \_\_\_\_\_ on \_\_\_\_\_
- Inspection** date/time of \_\_\_\_\_ / \_\_\_\_\_ communicated to patient by: \_\_\_\_\_
- Actual inspection was escorted by: \_\_\_\_\_ on \_\_\_\_\_